COLBERT V. QUINN, NO. 07-4737

Colbert Consent Decree

Implementation Plan Phase 2

Illinois Department on Aging

8/19/2014

TABLE OF CONTENTS

INTRODUCTION

A. Introduction

In August of 2007, several individuals filed a lawsuit, *Colbert v. Quinn*, 07 C 4737, seeking declaratory and injunctive relief to remedy alleged violations of Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. 12131-32, Section 504 of the Rehabilitation Act, 29 U.S.C. 794(a) and the Social Security Act, 42, U.S.C. 1396-1396v (SSA). Those plaintiffs alleged that they and members of their Class were being unnecessarily segregated and institutionalized in Nursing Facilities in Cook County in violation of the ADA and the Rehabilitation Act. Plaintiffs further alleged that the Defendants, specifically, the Governor of the State of Illinois and the directors of four state agencies (the Illinois Department of Human Services (DHS), the Illinois Department of Public Health (DPH), the Illinois Department on Aging (IDoA), and the Illinois Department of Healthcare and Family Services (HFS), denied them the opportunity to live in appropriate community integrated settings where they could lead more independent and productive lives.

Four years after the *Colbert* lawsuit was filed, a Consent Decree negotiated and agreed to by the Parties was approved on December 21, 2011, by United States District Court Judge Joan Lefkow. The Consent Decree requires the Defendants to make available to Class Members the following:

- Provide the necessary supports and services to allow them to live in the most integrated settings appropriate to their needs including Community-Based Settings
- Promote the development of integrated settings that attempt to maximize individuals' independence and choice, and their opportunities to develop and use independent living skills, and
- Afford Class Members the opportunity to live their lives similar to individuals without disabilities.

The Consent Decree requires the development of an *Implementation Plan* to define the strategies and mechanisms designed to meet the benchmarks and timeframes set forth therein. This document, principally authored by IDoA, satisfies the requirement of an Implementation Plan for the second phase of implementation of the Colbert Consent Decree. The Decree also requires a Cost Neutral Plan to maximize the number of Class Members offered the opportunity to move into Community-Based Settings and to ensure the process was no more costly in the aggregate than the status quo of placement and maintenance in a Nursing Facility.

When IDoA assumed the leadership of the Colbert Consent Decree in January 2014, the Court appointed Monitor had found the Defendants to be substantially out of compliance as documented in his November 23, 2013 annual report. IDoA immediately began the work to meet the recommendations stated in that report to achieve compliance with the Consent Decree. IDoA made significant improvements in certain

areas as reported by the Court Monitor in his Interim Report of June 3, 2014. Nevertheless, in that report, the Court Monitor continued to find the State out of compliance in the areas of Evaluation, Transition Planning and Community Placement. Details of the Court Monitor's recommendations, the State's responses to those recommendations and other Colbert Consent Decree implementation activities are found in the body of this document, titled *Colbert* Consent Decree Implementation Plan Phase II.

B. Pathways to Community Living/Money Follows the Person Program

Pathways to Community Living in Illinois was developed under the Money Follows the Person Rebalancing Demonstration, administered by the Center for Medicare and Medicaid Services (CMS) and authorized by the Deficit Reduction Act of 2005 and extended under Section 2403 of the Affordable Care Act. Illinois' Pathways to Community Living/MFP Program relies on a strong collaborative, inter-agency approach to the implementation of the program. The Department of Healthcare and Family Services (HFS) serves as the lead agency for Pathways and partners with the Department on Aging (IDoA), the Department of Human Services' Division of Mental Health (DHS/DMH), Division of Rehabilitation Services (DHS/DRS), and Division of Developmental Disabilities (DHS/DDD), along with the Illinois Housing Development Authority (IDHA) on the formation of policy and implementation issues related to MFP.

The goals of the Pathways to Community Living/MFP Rebalancing Demonstration Program include:

- Increase the use of Home and Community Based Services (HCBS) and reduce the use of institutionally-based services;
- Eliminate barriers and mechanisms in State law, State Medicaid plans, or State budgets that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive long-term care in the settings of their choice;
- Strengthen the ability of Medicaid programs to assure continued provision of HCBS to those individuals who choose to transition from institutions; and,
- Ensure that procedures are in place to provide quality assurance and continuous quality improvement of HCBS.

Illinois, along with 42 other states and the District of Columbia, have implemented the Pathways/MFP Demonstration Program. As of July 30, 2014, the Illinois Pathway Program has assisted 1407, individuals with transitioning to the community, 290 of whom are *Colbert* Class Members.

The second phase of implementation of the *Colbert* Consent Decree will continue to include processes meeting requirements of the Pathways/MFP Rebalancing Demonstration Program since the State projects over 90% of *Colbert* Class Members will be MFP participants. The State believes that these processes represent best practices in community reintegration.

COLBERT CONSENT DECREE

A. *Colbert* Consent Decree Requirements

The *Colbert* Consent Decree sets forth terms and a timetable for the State of Illinois to develop and implement necessary and sufficient measures and community based services and supports so that Class Members desiring to relocate to the Community may do so. The terms of the Decree specify the development and implementation of support and other resources, such as having service providers available and able to locate affordable housing, to arrange for Transition into Community-Based Settings, and to develop plans of care for Class Members transitioning to the Community that include accessing Community-Based Services consistent with the needs and choices of Class Members, and to ensure Defendants will meet their obligations under the Decree.

Requirements of the Consent Decree include the following:

- Annual Implementation Plans, with any amendments or updates filed with the Court to be incorporated into and become enforceable as part of the Decree.
- Documentation of the process and outcome of targeted communication, recruitment strategies of eligible Class Members.
- 500 Class Members will be evaluated by Qualified Professionals six months after implementation (May 2013) and 2000 Class Members will be evaluated by Qualified Professionals 18 months after implementation (May 2014).
- Placement of 300 Class members in community settings by November 8th, 2013; 800 total Class members placed by November 8th, 2014, and 1100 total placements by May 8, 2015.
- Completion of a Cost Neutral Plan submitted to the Court no later than June 8th 2015.

The Decree also requires Defendants to create and update annually an Implementation Plan that documents specific tasks, timetables, goals, programs, plans, strategies and protocols to assure that Defendants fulfill all of the requirements of the Decree. The Implementation Plan must also address the following requirements:

- Description of the hiring, training and supervision of the personnel necessary to implement the Decree;
- Description of the activities required to support the development and availability of Community-Based Services, Transition Costs, Home Accessibility Adaptation Costs and/or housing assistance and Community-Based Settings, including inter-agency agreements, requests for proposals, mechanisms for housing assistance and other actions necessary to implement the Decree.
- Identification of any services or supports anticipated or required in service plans developed pursuant to the Decree that are currently not available in the appropriate

quantity, quality or geographic location, and might be required to meet the Decree's obligations.

- Identification of any necessary regulatory changes that govern Nursing Facilities to strengthen and clarify requirements for services to Nursing Facility residents and that provide for effective oversight and enforcement of all applicable regulations and laws; and
- Descriptions of the methods by which the Defendants shall ensure compliance with the obligations of the Decree.

Additionally, the *Colbert* Consent Decree requires a Cost Neutral Plan to be developed by the Parties and the Court Monitor. This Cost Neutral Plan is to be developed by June 2015once the Parties determine the actual net cost to the State for the first 800 to 1100 people who should be transitioned from Nursing Facilities to Community-Based Settings by that time. The Consent Decree further requires that the net cost to the State be determined by calculating, for each Class Member who moves from a Nursing Facility to a Community-Based Setting, the State's net annualized cost for the prior year's stay in the Nursing Facility and the subsequent net annualized cost of each Class Member once moved to the Community-Based Setting.

A work group was formed early in the implementation process to address the many issues inherent in properly identifying and analyzing all of the above costs. This work group will continue to meet monthly or as often as necessary to resolve cost identification issues and other matter related to the Cost Neutral Plan.

B. Court Monitor's Role

The *Colbert* Consent Decree provides that the Court will appoint an independent and impartial Monitor to be selected by the Parties. The Monitor is to evaluate the Defendants' compliance with the Decree, identifying actual and potential areas of non-compliance, mediates disputes bringing issues and recommendations to the Court. The Monitor also is to file written reports at least annually with the Court and the Parties. Since the implementation of the Decree, the Monitor has filed an annual report dated November 27, 2013, and a subsequent interim report dated June 3, 2014.

B.1. November 27, 2013 Annual Report

Defendants were found by the Monitor to be in compliance with the Consent Decree's requirements concerning Outreach and Education, but were found to be substantially out of compliance with the Decree's requirements regarding Evaluations, Transition Planning and Community Placement. The Monitor's major recommendations included:

- That the Governor's office take a visible and direct role in the oversight and management of *Colbert* Decree as a vehicle for cross-agency participation and shared accountability for outcomes
- That the lead agency role move from HFS to IDoA with the understanding that the next phase be a shared responsibility model that incorporates executive participation

- That IDoA conduct an analysis and articulate roles, skills and staffing needs and provide budgetary resources by December 2013
- That IDoA develop a revised Implementation Plan ("Phase Two") with final approval and implementation by July 1, 2014
- That the State Defendants immediately develop an interim plan to ensure continuity, enhanced attentions to Evaluations and challenges to community placement
- That the State Defendants temporarily suspend new Evaluations of Class Members and develop an integrated and more comprehensive Evaluation of identified Class Members who have been recommended for placement
- That the State Defendants simplify and consolidate processes for persons with SMI ("Serious Mental Illness") using the DMH *Williams* Consent Decree service model for similar populations under the *Colbert* Consent Decree

B.2. June 3, 2014 Interim Court Report

The State Defendants accepted the November recommendations (see above section). The Court Monitor completed an Interim Court Report dated June 3, 2014, indicating that the Defendants continued to be in compliance with the *Colbert* Decree Outreach and Education requirements and had made substantial progress towards compliance with the *Colbert* Consent Decree Evaluation, Transition Planning, and Community Placement requirements. Progress towards the seven recommendations is listed below:

- The Governor's Office appointed a representative to support the oversight and management of the *Colbert* Decree. The representative has facilitated inter-agency agreements and access to resources as well as participating in all major meetings regarding the implementation and management of the Decree and serves as a consultative resource for IDoA staff.
- The official transfer of the lead agency to the Illinois Department on Aging (IDoA) for the *Colbert* Decree occurred on January 21, 2014. The Governor's Office, IDoA, the Department of Human Services/Division of Mental Health and the Department of Healthcare and Family Services have supported the transfer and have collaborated to implement changes to move the work of the Consent Decree forward.
- IDoA staff completed an analysis of the roles, skills, staffing and budgetary resources in December 2013. IDoA established an Office of Transition and Community Relations to house *Colbert* project staff and a *Colbert* Project Director joined IDoA in January 2014. Budgets were developed for the balance of Fiscal Year 2014 and for Fiscal Year 2015.
- IDoA staff submitted a semi-annual report dated April 30, 2014, to the Court Monitor to serve as the foundation for a Fiscal Year 2015 Annual Implementation Plan. The Implementation Plan 2 will be submitted by the end of Fiscal Year 2014 as required.
- An interim "working plan" was completed to ensure continuity and enhanced attention to Class Member Evaluations as well as other identified challenges to community placement. Outcomes of the working plan were included in the April 2014 semi-annual report. Interagency Agreements and contract amendments were also used to transfer existing agreements to the IDoA and transfer *Colbert* service contracts from HFS.

- As required, the State temporarily suspended new Evaluations of *Colbert* Class Members in December 2013 because of unresolved concerns about compliance with the Consent Decree and overall competency and completeness of the Evaluations. The Evaluation format was changed; a new Evaluation tool was created and went into effect in February 2014. The new Evaluation tool was used for new Evaluations as well as for re-Evaluation of certain previously evaluated Class Members.
- The Governor's Office, IDoA DHS/DMH, and HFS agreed to refer *Colbert* Class Members diagnosed with SMI to community mental health agencies for transition and community mental health services. This process is consistent with the DHS/DMH *Williams* Consent Decree model. An Inter-Governmental Agreement was developed between IDoA and DHS/DMH for this arrangement.

OFFICE OF TRANSITIONS AND COMMUNITY RELATIONS

In January 2014, The Illinois Department on Aging (IDoA) assumed the role of lead agency for the implementation of the *Colbert* Consent Decree and established the Office of Transition and Community Relations to expedite the implementation of the *Colbert* Consent Decree. The Office implementation strategy features collaborative and community-based approaches to transition *Colbert* Class Members living in Nursing Facilities to the most integrated setting. *Colbert* Class Members are then provided with services and supports that are necessary to live independently in the Community.

The Office is responsible for monitoring and evaluating the development and implementation of this innovative service delivery system which combines the services of health, housing, and other social services as needed, to include employment services As the number of Class Members living independently increases, the Office will ensure that there are adequate and appropriate post transition services to support the needs of the Class Member. The Office will also identify changes needed to regulations that govern Nursing Facility residents to make certain that transitions from Nursing Facilities can occur as required by the Consent Decree.

A. Staffing

The Office of Transition and Community Relations is staffed with five FTEs: the *Colbert* Project Director, a Transition and Research Administrator, a Quality and Compliance Liaison, a Transition Specialist and a Project Assistant. Three remaining positions, a Housing Coordinator, a Managed Care Organization (MCO) Contract Liaison and an Administrative Assistant have yet to be filled. IDoA anticipates filling these positions by October 1 2014.

B. Inter-Agency Agreements

In order to ensure efficient community integration efforts, IDoA, DHS/DMH, and HFS have entered into an Inter-Agency Agreement to collaborate on certain Class Members that require community mental health services. Effective March 1, 2014, *Colbert* Class Members that require community mental health services are referred to DHS Division of Mental Health for community integration and placement under IDoA oversight. DHS/DMH and IDoA have agreed to certain responsibilities regarding community integration of such *Colbert* Class Members.

In addition to Medicaid Rule 132 Services, these *Colbert* Class Members will be able to access non-Medicaid services created for persons who require community mental health services transitioning from Nursing Facilities to Community-Based Settings. These services include the oversight of the Quality Administrator, Transition Coordination, Supported Employment, Supported Education and Recovery Drop-In Centers. This procedural change should significantly impact the rate at which *Colbert* Class Members are moved to Community-Based Settings because it is estimated that at least 50% of the *Colbert* Class Member population are and will continue to be persons diagnosed with SMI. This process is based on the model developed by DHS/DMH for implementation of the *Williams* Consent Decree.

IDoA will engage in an Inter-governmental Agreement with the University of Illinois at Chicago Assistive Technology Unit (UIC-ATU) to provide Assistive Technology and Accessibility Modifications needed by *Colbert* Class Members to enable them to maximize their independence as they move into the community. Additionally, training and research components by UIC-ATU will serve to promote increased effectiveness among service providers involved in the implementation of the Consent Decree and to properly document processes and outcomes for reporting and analysis.

C. Program Innovations

The Office of Transitions and Community Relations is planning to seek proposals from the provider community for a pilot project where a singular provider offers a comprehensive approach to service planning, housing location, transition services and care coordination for complex populations. Respondents will be required to include protocols for referrals, assessments, transition services as part of their continuum of required services and be willing to collect and submit data to IDoA. A detailed summary will be made available by September 30, 2014.

IMPLEMENTATION PLAN – PHASE TWO

This section sets forth the program requirements, provider roles and responsibilities, staffing and updated service delivery changes for Phase Two of the *Colbert* Consent Decree Implementation. A work plan and a flow chart detailing the implementation of the *Colbert* Consent Decree are attached as Appendix A and B respectively.

A. Outreach and Education

This section sets forth the outreach and communication strategies that ensure that *Colbert* Class Members (and their families and guardians, if applicable) are afforded easy access to information, assistance and supports. The availability of this information to Class Members is critical to their ability to understand their rights under the Consent Decree and to their ability to make informed choices regarding their options and opportunities. The State is committed to ensuring that information is accessible, factual, and easily understood regardless of primary language or reading ability to both Class Members and families who may be assisting them with their decisions.

To the degree possible, materials and methods of information sharing will reflect the realities of both the process involved in transitioning to more integrated community settings, the challenges of community living and the potential rewards in terms of quality of life.

During the first year of implementation, the State developed a variety of communication methods, described below, to impart information in multiple venues. For the second year of implementation, the State has expanded the scope of communications to include an informational Help Line, informational email and technical assistance. A description of the communication methods is provided below.

A.1. ADRC and ADRN

The Aging and Disability Resource Center for Aging (ADRC) and the Disability Resource Network (ADRN) is a collaborative effort of the United States Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS), created in 2003. ADRCs currently operate in over 350 community sites across 54 states and territories. The goal of an ADRC/ADRN is to inform the public about and streamline access to information about the full range of available long-term support options in a highly visible, non-threatening environment.

In 2011, Federal CMS provided funding to MFP states to enhance the collaboration between MFP and the ADRC networks. Illinois implemented a pilot program with three ADRCs that addressed the enhancement of outreach to Nursing Facilities through the employment of Transition Engagement Specialists. The pilot is being expanded to additional ADRC sites based on the successful implementation of the model, including the generation of referrals for *Colbert* and MFP.

The State will continue to contract with two Area Agencies on Aging, Age Options, Inc. and the City of Chicago Department of Family and Support Services (CDFSS) to conduct outreach

activities for Colbert Class Members in Fiscal Year 2015. The CDFSS formed an ADRC (renamed as "ADRN") in late 2012 and, in collaboration with the City of Chicago Mayor's Office for Persons with Disabilities is assigned to Colbert Class Members who reside in the city of Chicago. Age Options operates in suburban Cook County as an ADRC since 2008, and is responsible for outreach activities for Colbert Class Members who reside in suburban Cook County.

Each ADRC and ADRN is minimally staffed with two Transition Engagement Specialists to perform tasks related to the *Colbert* Implementation Plan. Engagement Specialists have graduate degrees in Social Work or related academic fields. Below is a summary of the work performed by the Engagement Specialists that began during the initial phase of the Implementation Plan. For Phase Two of the Plan, the ADRC and ADRN are tasked to create and implement a Peer Mentoring program. A brief summary of ADRC and ADRN responsibilities and a description of the Mentoring program are listed below:

- Travel to each Nursing Facility within Cook County at least once to provide onsite outreach and education.
- Prioritize and target outreach to any individuals referred by IDoA or another unit of Government.
- Hold individual and small group engagement and information sessions to educate *Colbert* Class Members, guardians, family members, Nursing Facility staff, and other program stakeholders regarding Class Members' rights to live in the community and/or receive community based services, transition costs, home accessibility adaptation costs, and/or housing assistance, including the available options and opportunities for doing so. Maintain documentation of the individual and small group sessions with the dates and names of the individuals who attended these sessions to be made available as needed or requested.
- Refer individuals identified through outreach and education activities to be assessed for transition from institutions to Community-Based Settings through the Pathways to Community Living/MFP Web Application which is a website administered by HFS.
- Educate Nursing Facility staff and administrators regarding the *Colbert v. Quinn* Consent Decree, the Pathways to Community Living/MFP initiative, and other community based alternatives to institutional care.
- Ensure that there is active involvement and ongoing collaboration between the ADRN and the Mayor's Office for Persons with Disabilities.
- Establish a Peer Mentoring program to educate *Colbert* Class Members regarding their right to live in the community and/or receive community based services, transition costs, home accessibility adaption costs, and/or housing assistance, including the available options and opportunities. The Peer Mentoring program will recruit, identify and train *Colbert* Class Members or other individuals with disabilities who have moved from Nursing Facilities to Community-Based Settings. Peer mentors are to be trained to assist Transition Engagement Specialists as they conduct individual and small group engagement and information sessions to educate *Colbert* Class Members, guardians, family members, Nursing Facility staff and other program stakeholders regarding the *Colbert* Consent Decree and the services available for *Colbert* Class Members. Peer

mentors will receive $50.00 stipends for their role in the program. A detailed description of this program including goals, objectives, recruitment methods, training curriculum, and budgets, was submitted to IDoA for approval on July 15, 2014 with implementation to occur within 30 days after written approval by IDoA. IDoA staff will monitor implementation of this program through 1) review of monthly activity reports that detail the number of peer mentor visits to nursing facilities and, 2) review of quarterly expenditure reports that will document stipend expenditures.

A.2. Ombudsmen

Ombudsmen have been engaged by IDoA to assist in the identification of *Colbert* Class Members desiring to transition to the community regardless of the type of disability under the Pathways to Community Living/MFP program. The Ombudsmen will also continue to provide information and make referrals for Evaluation *Colbert* Class Members who are interested in transitioning to Community-Based Settings.

A.3. Written Materials

IDoA will revise existing outreach materials and develop new materials as necessary. These materials will be widely distributed and regularly updated to inform *Colbert* Class Members, *Colbert* Class Member families, Nursing Facility staff and other interested parties about the opportunities afforded as a result of the *Colbert* Consent Decree as well as appeal, complaint and grievance procedures in effect for *Colbert* Class Members engaged in the *Colbert* Consent Decree implementation process.

A.4. Informational Videos

Colbert and MFP informational videos created by HFS will continue to be used by Transition Engagement Specialists to inform *Colbert* Class Members, *Colbert* Class Member families, Nursing Facility staff and other interested parties about the opportunities afforded to Class Members as a result of the *Colbert* Consent Decree. The HFS informational video is also featured on the IDoA *Colbert* webpage.

A.5. Colbert Webpage

The IDoA website has been updated to include the *Colbert* Consent Decree Information Page. *Colbert* Consent Decree related documents are *Colbert* Implementation Plan, and *Colbert* Fact Sheets. In addition, this webpage offers links to the *Colbert* Information Email address, the *Colbert* Video as well as the Pathways to Community Living/MFP website and referral link.

A.6. Colbert Information Email

A *Colbert* information email account (AGING.ColbertDecree@Illinois.gov) was created to allow *Colbert* Class Members, *Colbert* Class Member families, Nursing Facility staff and other interested parties the opportunity to ask questions and make comments via email. The Colbert Informational email address is displayed on the Colbert webpage and will be included in updated written outreach materials. The *Colbert* Technical Advisor will respond within two business days to questions raised regarding the *Colbert* Consent Decree process including specific questions regarding *Colbert* Class Member status on the *Colbert* transition continuum.

A.7. Colbert Information Line

Effective September 1, 2014, *Colbert* Class Members will have access to an informational telephone line Monday through Friday, 8:30 a.m. through 5:00 p.m., operated by IDoA. The informational telephone line number will be included in updated written outreach materials and on the Colbert webpage. Colbert Class Members, Class Member families, Nursing Facility staff, and other interested parties will be able to ask questions, and initiate referrals using the Colbert Informational Line.

Agents staffing the informational telephone line will be trained to answer general questions regarding the *Colbert* Consent Decree and its implementation. Those calling with specific questions regarding *Colbert* Class Members who have been referred, assessed, or otherwise engaged in *Colbert* implementation activities will be referred to a *Colbert* Technical Advisor for follow-up.

B. Referrals

Referrals for *Colbert* Class Members to be assessed for transition from Nursing Facilities to Community-Based Settings are expected to come from a variety of sources to meet the requirements of the *Colbert* Consent Decree and to address the needs of the *Colbert* Class. Referrals can be made by the Class Member through self referral, family members or friends, Nursing Facility staff, Transition Engagement Specialists, Ombudsmen, MCO Care Coordinators, class counsel and others.

As all *Colbert* Class Members are potential MFP participants, the web referral form found on the MFP website is the primary vehicle by which *Colbert* Class Members are referred to one of two Managed Care Organizations (MCOs) under contract with the IDoA for initial contact and potentially Evaluation. The users of the referral form include those Class Members identified by nursing staff through administration of the federally mandated Minimum Data Set (MDS) assessment process. The on-line referral form, designed to be used by the general public to refer residents of Nursing Facilities in Illinois to be assessed for transition to Community-Based Settings, is user-friendly and widely distributed. *Colbert* Class Members will also be able to use the *Colbert* Informational Line or Email for referral.

All assigned referrals are monitored by HFS for follow-up by the Managed Care Organization (MCO) within the federally mandated 10 business day time period. This is accomplished by monitoring the completion of a First Contact form in the MFP web application which indicates that the individual contacted is either considered appropriate for transition or not and documents the referral status rationale.

HFS will provide IDoA with a list of referrals on a weekly basis and is capable of providing referral data according to source for planning and analysis.

C. Evaluations and Care Coordination

IDoA has contracted with Aetna Better Healthcare, Inc. and IlliniCare Healthplan, Inc. to provide inter-disciplinary teams comprised of Qualified Professionals to manage processes required by the *Colbert* Consent Decree that are necessary to the successful transition to Community-Based Settings from Nursing Facilities. Those processes include Evaluation, development of a Service Plan of Care, monitoring throughout transition and for 12 months post-transition. Each team shall consist of:

- One Health Care Professional – a licensed nurse with a minimum of two years prior direct service experience working with adults with physical disabilities or mental illness or older adults with disabilities who will focus on the Class Member's physical health issues
- One Behavioral Health Specialist – a Master level Clinical Social Worker with a minimum of two years prior direct service experience working with adults with physical disabilities or (SMI) or older adults with disabilities, who will focus on the mental health and social issues of the Class Members; and
- One or more MCO Care Coordinators – a Bachelor level professional with a degree in a health or human service area, or a Master's degree in Social Work and a minimum of two years of prior direct service experience working with adults with physical disabilities or SMI or older adults with disabilities.

C.1. Evaluations

Colbert Class Members interested in transitioning to a Community-Based Setting are to receive a high quality, clinically informed assessment and collection of information that will be used to assemble a full picture of the individual's preferences, strengths, needs, service patterns and outcomes over time. In accordance with the *Colbert* Consent Decree, this Evaluation by a Qualified Professional, who is knowledgeable of populations with special and often complex needs, will be used to determine what community based services would allow the Class Member to transition to and live successfully in a Community-Based Setting.

C.2. Evaluation Tools

The multi-disciplinary team will continue to conduct the Evaluations in accordance with the requirements of the Consent Decree as described above. The Evaluations will be conducted using the Evaluation tools approved by a workgroup, formed with representatives from HFS, IDoA, Aetna Better Healthcare, Inc. and IlliniCare Healthplan, Inc. This workgroup's task was to review and revise Aetna Better Healthcare, Inc. and IlliniCare Healthplan, Inc.'s respective Evaluation tools in accordance with best practice and the requirements of the *Colbert* Consent Decree. The workgroup reached a consensus on amending the Evaluation tool in January 2014. The MCOs were instructed in February 2014 to begin using the new instrument by reevaluating many of the Class Members who had been previously evaluated using what was considered an inadequate Evaluation tool.

The Determination of Need (DON) is an assessment utilized by DRS (individuals under age 60) and IDoA (individuals over age 60) and is used in addition to the MCO Evaluation tool when assessing services available for persons with disabilities. A score is derived from the DON tool that determines the level and/or quantity of services available to the individual. The DON is composed of a Mini-Mental Status Exam and the assessment of level of functioning in six activities of daily living, nine instrumental activities of daily living, as well as the ability to perform certain health tasks and to recognize and respond to danger when left alone.

Information garnered from the new Evaluation tool, the DON, Nursing Facility medical record reviews, and interviews with the Class Member as well as his or her support system will inform the evaluator regarding the community based services necessary for the Class Member to transition to a Community-Based Setting.

C.3. Evaluation Disposition Reporting

MCO staff will report the dispositions of the Evaluations according to categories defined by IDoA on a weekly basis. IDoA staff will use this data to monitor Evaluation activity, the flow of referrals to the housing locator agencies, and the community mental health centers, as well as to inform monthly *Colbert* Consent Decree compliance reports.

C.4. Community Mental Health Services

If it is determined by the MCO that the Class Member requires community mental health services to successfully live in a Community-Based Setting, the MCO will refer the Class Member to a CMHC in the geographic location of his or her choice. The Class Member will receive further specialized assessment of his or her mental health condition, an individualized service treatment plan, transition coordination services and prescribed community mental health and other required social, employment or health care services. In most cases, once a Class Member is referred to a CMHC for mental health services, the CMHC will assume the responsibility to amend and manage the Service Plan of Care. The MCO will only continue to manage the Service Plan of Care when a physical and/or a medical condition are dominant.

C.5. University of Illinois- Chicago Assistive Technology Unit

If it is determined that a Class Member with a physical disability requires additional support and Home Accessibility Adaption modifications in a Community Based Setting, the evaluator may request the University of Illinois at Chicago Assistive Technology Unit (UIC-ATU) to determine what assistive technology may be required and to recommend accessibility modifications needed by the *Colbert* Class Member to maximize their independence as they move into the community (see Section H for Accessible Housing for additional information). As stated in the Consent Decree, IDoA will provide a onetime payment of $5000.00 for allowable expenses necessary to make a Community Based Setting accessible for a Class Member.

C.6. Social History

When the Class Member is interested in moving to a Community-Based Setting and the evaluator determines that services are available for him or her to successfully live in a Community-Based Setting, a social history will be completed, that provides a narrative of the

Class Member's personal history and goals, to the extent that he or she wishes to share it. This information will be used when developing the Service Plan of Care and is included in the assessment packet that is provided for the CMHC when appropriate.

C.7. Service Plan of Care

In accordance with the *Colbert* Consent Decree, the MCO Care Coordinator will develop a Service Plan of Care for each consenting Class Member who is recommended for transition to a Community-Based Setting within 90 days of his or her Evaluation. Consistent with new federal home and community based service requirements, Service Plans of Care are to be developed incorporating a person-centered planning process that addresses health, disabilities and long-term services and support needs in a manner that reflects individual preferences and goals. That is, the service planning process is to be directed by the Class Member and may include another individual that the Class Member chooses to be included. This process should result in a person-centered plan that reflects goals and preferences identified by the Class Member.

The purpose of the resulting person-centered service plan is threefold: (1) to assist the Class Member in achieving personally defined outcomes once transitioned to the most integrated Community-Based Setting; (2) to ensure delivery of services in a manner that reflects personal preferences and choices; and (3) to contribute to assuring the health and welfare for the Class Member. As required by the Consent Decree, the Service Plan shall focus on the Class Member's personal vision, preferences, strengths and needs in home, community and work environments.

The MCO shall update each Service Plan of Care at least every 180 days to reflect any changes in the needs and preferences of the Class Member, including his or her desire to move into a Community-Based Setting after declining to do so, and shall incorporate, where appropriate, services to assist in acquisition of basic activities of daily living skills and disability self-management.

If the Class Member is not referred to Permanent Supportive Housing or a Private Residence, the Service Plan of Care will specify the services to be provided at the alternate setting. *Colbert* Class Members who meet the eligibility criteria for a federal waiver may have access to a wide range of additional services (see Appendix C). The State looks forward to the approval of its recently submitted 1115 federal waiver application so that all persons with special needs who are eligible can expand the types of waiver services used, based on functional need, regardless of their disability.

If the Class Member is not recommended for transition to a Community-Based Setting because the service array does not meet their needs and those needs do not require continued placement in a 24-hour skilled nursing care, the MCO Care Coordinator will document the services necessary in the Service Plan of Care for the Class Member's successful transition to a Community-Based Setting. The Service Plan of Care shall specify what services the Class Member needs that cannot be provided in any Community-Based Setting. The MCO Care Coordinator will review and update the Service Plan of Care every 180 days. Data regarding

services necessary to a Class Member's successful transition to a Community-Based Setting that are not available in the appropriate quantity, quality, and geographic location will be collected. The State will use this data for service planning and development.

C.8. Discharge Service Plan Conference

MCO Care Coordinators, CMHC staff and other service providers will continue to collaborate to ensure that all of the Class Member's needs are addressed. While many teleconferences are conducted during the course of the Class Member's transition, during which his or her needs are discussed along with approaches to meet those needs, at least two (2) in-person care conferences will be conducted prior to the Class Member's transition to a Community-Based Setting. These care conferences will include the Class Member and the significant other of his/her choice, the guardian, if applicable, the MCO Care Coordinator, any relevant service providers and, if possible, a Nursing Facility staff member that is knowledgeable about the care that is being provided to the Class Member in the facility and who has the authority to arrange the Class Member's discharge, provide his or her medications, etc.

C.9. MFP Transition Requirements

In recognition of MFP requirements and best practice, certain other documents are completed by the MCO Care Coordinators or CMHC staff prior to transitioning an individual from an institution to a Community-Based Setting. They include:

- Risk Inventory and Mitigation Plan
  The Risk Inventory identifies risks pertinent to the individual's safety and then links those risks with proven mitigation strategies designed to reduce those risks.
- 24 Hour Back-up Plan
  The 24 Hour Back-up Plan involves the Class Member being given a written document that lists resources and supports for his or her use in the event of an emergency or as a remedy for loneliness. Class Members will be coached frequently regarding the resources listed on the 24 Hour Back-up Plan to ensure that the Class Member has access to a telephone for use in emergency situations.
- Quality of Life Survey
  The baseline Quality of Life survey is to be completed two weeks prior to the Class Member being discharged from the Nursing Facility (See the Quality section for more details).

The Risk Inventory, 24 Hour Back-up Plan and Quality of Life Survey will be completed and submitted appropriately prior to discharge from the Nursing Facility.

D. Post-Transition

Effective care coordination and post-transition monitoring is critical to the success of *Colbert* Class Members' transition to Community-Based Settings. The MCO Care Coordinators or the CMHC staff, will provide comprehensive care coordination services and ensure that the needs of Class Members are identified and addressed through referrals for all available services for which the Class Member is eligible for 12 months post transition. MCO Care Coordinators and

CMHC staff will also: (1) provide assistance with arranging transportation, (2) verify and assist with adherence to medication therapy and, (3) verify and assist with attendance at medical appointments, and 4) assist Class Members to secure permanent housing subsidies. MCO Care Coordinators and CMHC staff shall document all contacts with the Class Member, legal guardian, family, friends, significant others where applicable, and other providers on the *Colbert* Class Member Transition Tracking system. These contacts are to occur in accordance with MFP guidelines, including:

- First month – Face to face with the Class Member, two times weekly with the designated contact or service provider.
- Second month – Face to face with the Class Member as needed, weekly contact with the designated contact or service provider.
- Third through twelfth month - Face to Face as needed and contact with designated contact as needed.

After the 12th month post-transition, the Class Member's care coordination will be transferred to the Class Members' elected Managed Care Entity (MCE). If the Class Member has not selected a Managed Care Entity, the Class Member will be referred to an Illinois Client Enrollment Broker for engagement. There is a contractual provision that requires MCOs contracted with the State to continue established Service Plans of Care unless the Class Member and his guardian, if applicable, agree to a modification. Additionally, the MCOs must 1) allow a 180 day transition period for Class Members enrolling in their plan before making any provider changes and, 2) provide information to out of network providers on becoming network providers.

D.1. Colbert Class Member Skill-Building

The State recognizes that individuals leaving Nursing Facilities after long stays may lack certain life skills necessary to function well and thrive in a community. Part of the Evaluation process conducted by the MCO Care Coordinators and CMCH staff is to assist Class Members to articulate what skills they have and what skills they need to master. Financial management, accessing and using transportation, shopping, and medication management are some of the skills that are essential for Class Members to maintain the ability to reside in a Community Based Setting. These skills may not be utilized by Class Members while residing in a Nursing Facility.

The Service Plans of Care and Mental Health Treatment Plans, completed by MCO Care Coordinators, CMHC staff and Class Members, use a person-centered approach and contain language and opportunities to access services that reinforce independent skill development. In addition, Class Members will have access to a continuum of programs and services as well as a treatment approach that supports the challenge of managing a disability and independent living, to include Supported Education and Employment, as appropriate.

The Department of Rehabilitative Services (DRS) is also working to support skill development by contracting with Access Living to provide the following services to Colbert Class Members:

- Money Smart (a FDIC approved financial management curriculum) to support financial management
- Training to manage personal assistants
- Training to access Emergency Back-up CNA referrals and services
- Stepping Stones for Individuals and Groups - a comprehensive peer support curriculum for persons with disabilities to learn vital independent living skills (i.e. positive disability identity and self-advocacy, technology, harm protection, rights and legal protection, maintaining healthy relationships, budgeting).

E. Housing

Stable housing is essential to successful community integration. IDoA intends to ensure that Class Members are provided the opportunity to live in the most appropriate integrated setting where they can lead independent and productive lives in the community. This requires an approach that is flexible, adaptable and individualized. IDoA's priorities are to maximize housing options that address the environmental safety and emotional wellbeing of Class Members and to assure essential services and supports. Working closely with the Governor's Office of Health Innovation and Transformation (GOHIT), IDoA will identify and develop an array of housing options designed to address the full range of individual needs of those Class Members who elect to transition.

The Governor's Office of Health Innovation and Transformation (GOHIT) provides Housing Coordinators whose responsibility is to identify means of enhancing housing opportunities for special needs populations, including Class Members. The Coordinators responsibilities include expanding housing resources through the development and expansion of networking opportunities, partnerships and relationships with landlords, housing developers and public housing agencies hereby facilitating the expansion of housing resources including Permanent Supportive Housing (PSH), housing opportunities for Class Members of the Consent Decrees and management of the referral flow to IHDA's Low Income Housing Tax Credit Units. A portion of IHDA's Low Income Housing Tax Credit units are targeted to persons with disabilities and referred through a State referral network that includes, but is not limited to, Class Members of the *Olmstead* Class Actions.

The IDoA staff also will work closely with the Housing Specialist Agencies (HSAs), the Community Mental Health Centers (CMHCs) and the fiscal agent subsidy administrator to identify housing options for individual Class Members and to resolve obstacles to finalizing placements. The housing activities will be largely the same for Class Members with physical disabilities and those with diagnoses of SMI. But the HSAs, in coordination with the MCO Care Coordinators at the MCO's will carry out those activities for persons with physical disabilities, whereas the CMHC staff will carry out those activities for Class Members with diagnoses of SMI.

E.1. Housing Location

Colbert Class Members will need assistance in searching for housing and negotiating with landlords as well as to support transitioning from the Nursing Facilities to Community-Based

Settings. To meet these needs for Class Members with physical disabilities, IDoA has entered into contracts with three housing location and transition specialist agencies: FeatherFist, Access Living, and Heartland Human Care Services, Inc. To meet these needs for Class Members with diagnoses of SMI, IDoA is developing an Inter-Governmental Agreement with DMH for the provision of housing location and transition assistance by DMH-contracted CMHCs. The contracted CMHCs include Association House, Community Counseling Center of Chicago, Lutheran Social Services of Illinois, Heartland Health Outreach, Trilogy Inc., Thresholds, Pilsen Wellness Center, Kenneth Young Center, Sertoma Centre, and Grand Prairie Services.

E.2. Housing Specialist Agencies

The Housing Specialists work in conjunction with the MCO Care Coordinator and the Class Member to identify appropriate housing. The MCO Care Coordinator will work with each Class Member to determine geographic and housing preferences and options, including living with family, guardians, and friends and significant others. The MCO Care Coordinator will also assist the Class Member to obtain a State Identification Card, Birth Certificate or a Social Security Card and income verification. The Housing Specialists will work with each Class Member to identify housing using existing relationships with landlords, newspaper advertisements and housing identified through the Illinois Housing Search web based search engine (see below). Additionally, the Housing Specialists will work with the landlord and the Class Member to complete and submit applications, secure leases, an inspection of the unit, transition funds, ensure the unit is ready for move in, and in some cases, provide training on mobility/orientation to the Class Member's new community. Once housing is secured, the MCO Care Coordinator coordinates the Discharge Service Plan Conference, collects and transports medication from the Nursing Facility, and meets with the Class Member and the Housing Specialist on the day of the move.

E.3. Community Mental Health Centers

The MCO Care Coordinator will work with each Class Member to determine geographic and housing preferences and options, including living with family, guardians, and friends and significant others. Upon referral, CMHC staff are to secure necessary identification and income verification as part of their intake protocol. Staff also works with each Class Member to identify housing using existing relationships with landlords, newspaper and web/internet advertisements and housing identified through the Illinois Housing Search web based search engine (see below). Additionally, the Community Mental Health Centers will work with the landlord and the Class Member to submit applications, secure leases and transition the Class Member into the unit.

Once housing is secured, CMHC staff coordinates the Discharge Service Plan Conference, collect and transport medication from the Nursing Facility. CMHC staff and MCO Care Coordinators will determine which staff will provide medication management during the Discharge Service Plan Conference for those Class Members diagnosed with SMI that have medical co-morbid conditions.

F. Housing Resources and Options

Both the Housing Specialist Agencies and Community Mental Health Centers are able to use any of the resources listed below as appropriate to expedite *Colbert* Class members' transition to Community-Based Settings.

F.1. Illinois Web Based Housing Search

The primary on-line State funded housing search inventory is the Illinois Housing Locator, www.ILHousingSearch.org. Class Members, CMHCs and Housing Specialists can access this site, which lists housing by location, features, vacancy, and other criteria. Housing Specialists and CMHCs will have secure access to a web portal that enables them to search for housing options that may be targeted to populations represented by the various Consent Decrees. This option further advances the ability to access additional and more detailed housing information relevant to the populations they serve.

F.2. Statewide Referral Network

IHDA and DHS partnered to create quality, affordable apartments for supportive housing populations: individuals and families who are homeless, at risk of homelessness, and/or have disabilities, and who require access to supportive services in order to maintain housing. The Statewide Referral Network (SRN) links vulnerable populations, who are already connected to services, to affordable, available housing. It is managed by the GOHIT Statewide Housing Coordinator, who works with five regional Lead Referral Agents (LRAs). The LRAs receive referrals from various service providers in their region, verify eligibility and then send those referrals on to owners or property managers for their consideration as tenants. CMHCs and Housing Specialists can access the Statewide Referral Network units by submitting applications with the Class Member to the GOHIT Statewide Housing Coordinators.

F.3. Permanent Supportive Housing

Permanent Supportive Housing (PSH) market linked to housing with flexible community based support services that are available to tenants when needed, but are not mandated as a condition of living in the housing unit. These supports could include homemaker service, personal assistance, mental health or substance abuse services and assistance in arranging medical appointments or reminders to pay the rent. The PSH model is based on a philosophy that is recovery oriented and supports Class Member choice and empowerment, rights and responsibilities of tenancy, and appropriate, flexible, accessible, and available support services that meet each Class Member's changing needs. PSH units range from self-contained studios to one to three bedroom apartments, inclusive of a kitchen or kitchenette and bathroom. PSH units may also be shared apartments, per mutual agreement of the residents. PSH units are considered permanent residences. As such, Landlord/Tenant Law applies to this housing model. Tenants hold their own leases or rental agreements with respective developments, property management companies or landlords. In accordance with the IDoA model of PSH with a Bridge Subsidy, all eligible units must meet Fair Market Rate (FMR) or Payment Standard criteria (unless an exception is warranted, as defined by IDoA) and pass Housing Quality Standards (HQS) inspection. There are numerous Scattered-Site and Site-Based PSH options throughout

Cook County managed by various entities; CMHCs and Housing Specialists can access these resources directly and will also be provided additional support from IDoA to access these units.

F.4. Scattered-Site Permanent Supportive Housing

PSH may utilize scattered-site rental apartments/units from an array of safe, decent and affordable fair market, open housing stock (usually rental apartment/units, but not restricted as such). Participation in the open housing market, with provider assistance, affords *Colbert* Class Members greater choice as to where they will live, with whom they will live (if they choose not to live alone), and which services and supports to use. Under the scattered site PSH model, supportive services are available, appropriate to the needs and preferences of residents, either on-site or in close proximity to the housing, and more likely to be delivered confidentially.

F.5. Site-Based Permanent Supportive Housing

Site-Based PSH offers services on site. These housing developments have typically been dedicated to a single disability or population type, provide community support and services for residents and offer economies of scale for service provision. Site-Based PSH projects are generally smaller developments. This model offers on-site services to those members of the *Colbert* Class who need a higher or more immediate service level. While development dedicated to a single disability type would clearly not meet the requirements of the Consent Decree, the model allows for units that serve the general population including persons with other disabilities. Additionally, it will afford the State the ability to secure a set number of units within a project/building to address immediate and long range planning.

*F.6. Project-Based Master Lease*s

In FY15, IDoA is planning to utilize Project-Based Master Leasing as an approach to housing *Colbert* Class Members who have barriers to accessing leases in the open market such as criminal or credit backgrounds. The goal of Project-Basing is to identify specific housing options (scattered sites, or a set number of units in a building) that can more immediately be accessed through this pre-determined lease arrangement. Project-Basing is designed as a flexible resource to create a variety of housing options in terms of housing type, density, and location. Through the project-basing approach, which is primarily focused on existing rental housing, the following occurs: 1) execution of long-term Housing Assistance Payment (HAP) contracts (2-3 years) with property owners of quality rental housing; 2) securing units at a discounted rate because of long term arrangements; and 3) guaranteed payment for open units resulting in securing a specific targeted number of rental units. CMHCs and Housing Specialists will be provided regular listings of vacant Colbert Project-Based units by IDoA and can access the units by submitting applications with the Class Member directly to the landlords.

F.7. Clustered Model

In FY15, IDoA is planning to use the Cluster Model as an approach to housing *Colbert* Class Members who may require staff support on site. Using the project-based Bridge Subsidy, the Clustered Model allows for a set number of residential units in a building or small geographic area to be secured with a HAP contract. An additional residential or commercial unit is also leased under the contract for low to medium level service agency staff to be on-site 24 hours a

day. To meet the individualized and diverse housing needs of *Colbert* Class Members, IDoA will be seeking interested private-market owners and landlords to participate in a clustered model of supportive housing. Once developed, CMHCs and Housing Specialists will be provided regular listings of vacant Colbert Clustered-Model units by IDoA and can access the units by submitting applications with the Class Member to IDoA.

F.8. Project Based Section 8

Project Based Section 8 gives landlords the ability to rent their apartments to very low income and extremely low income tenants. If a property has a Project Based Section 8 contract (or similar project based rental/operating assistance), the landlord has agreed to a rent standard (up to Fair Market Rent or Local Payment Standard) with the contract administrator; the property can then rent to low income tenants who pay 30% of their income towards the rent; the remainder of the rent is paid by U.S. Department of Housing and Urban Developoment through the contract administrator. There are a large number of units in the community that have Project Based subsidy and eligible Public Housing Agencies (PHA) have the option to convert a percentage of their Housing Choice Vouchers (see below to G. Funding Sources and Options). CMHCs and Housing Specialists will assist Class Members identified as being on the Public Housing Authority waitlists to access the Project-Based Section 8 units by submitting applications with the Class Member directly to the Public Housing Authority.

F.9. Section 811 Supportive Housing

The Section 811 Supportive Housing for People with Disabilities program assists low income households with long-term disabilities to live independently in the community by providing affordable housing linked with voluntary services and supports. Starting in FY15, the new Section 811 program will create thousands more units of integrated permanent supportive housing every year by: (1) providing stronger incentives to leverage other sources of capital for 811 units, including federal Low Income Housing Tax Credits, HUD HOME funds, and bond financing; (2) authorizing a 'stand alone' Project Based Rental Assistance approach to help state and local governments systematically create integrated supportive housing units in affordable rental housing developments. The legislation also permanently transfers Section 811 funded vouchers to the Housing Choice Voucher program and ensures that other Housing Choice Vouchers appropriated by Congress for non-elderly people with disabilities continue to be used for that purpose. CMHCs and Housing Specialists can access the Section 811 units by submitting applications with the Class Member to the GOHIT Statewide Housing Coordinators.

F.10. Home First Illinois Initiative

To address the need for integrated housing for people with disabilities, IFF and Access Living launched Home First Illinois (HFI). Through this initiative, IFF will develop, own, and manage accessible homes—integrated within the community—that will remain permanently affordable to very low-income people with disabilities. HFI develops integrated, accessible, and affordable homes, providing permanent, community based housing to people with disabilities. These homes address a strong need for accessible housing in Illinois. IFF designed HFI to focus on the development and operation of integrated, permanent housing options for people with disabilities who wish to live in the community. HFI acquires and develops scattered-site

housing, with an emphasis on increasing accessible housing options. HFI owns the units and oversees the property manager, so that residents have an informed and committed landlord, and partners with providers that help residents' access community based services. Because people with disabilities often have extremely low incomes, HFI ensures that each unit has a source of rental subsidy so that tenants will have enough disposable income for food, transportation, and out-of-pocket medical costs. CMHCs and Housing Specialists will be provided regular vacancy listings for HFI units and can access the units by submitting applications with the Class Member directly to HFI.

F.11. Low Income Housing Tax Credits Units

A portion of IHDA's Low Income Housing Tax Credit units are targeted to persons with disabilities and referred through a State referral network that includes, but is not limited to, Class Members of the Consent Decrees. CMHCs and Housing Specialists can access the Tax Credit units by submitting applications with the Class Member directly to the properties.

F.12. Collaboration with Public Housing Authority (PHA) and IHDA

The GOHIT Housing Coordinators and IHDA are working with local Public Housing Authorities to increase the availability of access by Class Members to their rental assistance programs and units. This collaboration is developing methodologies within the context of existing HUD policy guidance for both tenant-based assistance and project-based units. Examples include enhancing the availability of Housing Choice Vouchers for the elderly and persons with disabilities, as well as obtaining access for Class Members to vacant public housing units that exist within certain public housing authorities in the State. They are also exploring referral mechanisms to allow Class Members to more easily access accessible and adaptable Project Rental Assistance (PRA) units and units within PHA senior developments.

G. Funding Resources and Options

G.1. Colbert Bridge Subsidy

Many *Colbert* Class Members will have income, limited to entitlements such as SSI/SSDI, and require assistance with rental payments. The *Colbert* Bridge Subsidy is designed to bridge the gap between when an individual transitions into his or her own community housing unit and the time that they can secure a more permanent rental subsidy (e.g. Section 8 Housing Choice Voucher, IHDA's Rental Housing Support Program, any other comparable permanent rental subsidy), or can otherwise achieve an increase in their income. The *Colbert* Bridge Subsidy provides essential, interim support to individuals transitioning into Permanent Supportive Housing and can also be project-based for specific units. Key components of the *Colbert* Bridge Subsidy are:

- Designed to look like the Section 8 Housing Choice Voucher, the tenant is obligated to pay 30% of their income each month toward rent and the subsidy rental assistance pays the remainder of the rent each month directly to the landlord.
- Housing Transition Funds will be available to provide one-time, move-in assistance for costs such as security deposits/move-in fees, utility deposits, and the acquisition of basic household items. The Housing Specialist will coordinate the needs of a transitioning

Class Member and make the necessary arrangements to secure these items. Neither the Class Member, family member, nor the guardian, will have direct access to Housing Transition Funds. These funds are managed and reconciled with the IDoA Bridge Subsidy Administrator and the Housing Authority of Cook County (HACC). The Consent Decree states that transition costs for each Class Member shall not exceed $4,000 over a lifetime.

- All identified housing units must fall within the Fair Market Rental (FMR) or Local Payment Standard. Exceptions may be made in appropriate cases as defined by IDoA – for example, where exceeding the FMR is necessary to obtain certain accessibility features needed by a tenant with a disability.
- Once the unit has been located, CMHCs and HSAs arrange for a Housing Quality Standards (HQS) inspection. This inspection must occur before the Bridge Subsidy can be approved. Once approved, the Class Member will be responsible for signing a lease with the landlord and will be subject to the same tenant/landlord law as all other lease holding tenants. CMCH staff and HSA staff will assist with both.

G.2. Fiscal Agent Subsidy Administration

The Housing Authority of Cook County (HACC) is contracted with IDoA to administer the *Colbert* Bridge Subsidy, with responsibility for the following activities and functions:

- Coordinate efforts with the Class Member and their MCO Care Coordinator or the CMHC staff to certify the income of the Class Member;
- Assist the Class Member and the Housing Locator Specialist or the CMHC staff with lease preparation, and execution;
- Complete or contract for initial Housing Quality Standards (HQS) inspections on units located by each MCO Care Coordinator or CMHC staff and the Class Member using the U.S. Department of Housing & Urban Development (HUD) approved HQS forms;
- Conduct or contract for annual re-inspections of the unit within the outlined timeline;
- Negotiate unit rental price with landlord or property manager, in conjunction with Class Member, Housing Locator and MCO Care Coordinator, that meet FMR standards, Local Payment Standard limitations, and other local factors, if applicable;
- Disperse Transition Funds (for Class Member move in) per IDoA directives; for security deposit, utility deposit, and application fee and/or credit check;
- Utilize Income Verification form(s) and executes the Housing Assistance Payments (HAP) Contract with the landlord/property manager on behalf of the Class Member;
- Disburse monthly rental payments in accordance with HAP Contracts; Complete interim income certifications with tenants, as necessary; and
- Complete annual tenant income re-certification.

G.3. Permanent Housing Subsidies

Colbert Class Members transitioning under the *Colbert* Consent Decree, assisted by the MCO Care Coordinator, must agree to apply for Section 8 Housing Choice Vouchers or other comparable permanent rental subsidy, or agree to accept the subsidy if and when such options become available. The State of Illinois will work with Public Housing Authorities (PHA) and

other entities that administer and distribute housing rental subsidies in an effort to transition Class Members from the *Colbert* Bridge Rental Subsidy to permanent housing subsidies. IDoA will work closely with MCOs, Housing Specialists and CMHCs to identify Class Members needs and eligibility for the various permanent funding resources below, and connect them to the relevant subsidy administrator.

G.4. Housing Choice Voucher

The Housing Choice Voucher program is the federal government's major program for assisting very low-income families, the elderly, and persons with disabilities to afford decent, safe and sanitary housing in the private market. Housing choice vouchers are administered locally by PHAs. Eligibility for a housing voucher is determined by the PHA based on the total annual gross income and family size. In general, the family's income may not exceed 50% of the median income for the county or metropolitan area in which the family chooses to live. By law, a PHA must provide 75% of its vouchers to applicant whose incomes do not exceed 30% of the area median income. Voucher holders may rent from any landlord that accepts Housing Choice Vouchers. The voucher holder pays 30% of their income towards rent and utilities. HUD, through the PHA, pays the balance of the rent up to the agreed upon payment standard (usually the local fair market rent).

G.5. Illinois Rental Housing Support Program (RHSP)

Illinois Rental Housing Support Program is a State-funded rental assistance program developed with annual appropriation of approximately $25-30 million. RHSP is designed to provide long term assistance for permanent housing. Resources are allocated statewide based on a formula, with the Chicago administered program receiving 43% of resources. Illinois Housing Development Authority (IHDA) administers the program for the balance of the State. On a per year basis, 10% of the funding under RHSP is available as the Long Term Operating Support (LTOS) Program to provide up to fifteen (15) years of long-term, project based, rent subsidy to newly available affordable units, in order to increase the supply of affordable housing to households earning at or below 30% Area Median Income (AMI).

G.6. Long Term Operating Support (LTOS) Program

On August 3, 2012, Governor Quinn signed into law a modification of the RHSP that allows IHDA to target LTOS to persons with disabilities. Concurrently, IHDA released a Request for Applications for a demonstration LTOS program. The new LTOS program requires owners who participate to take referrals from the Statewide Housing Referral Network, and is anticipated to create 150 newly assisted units of housing for the Target Population. LTOS program is part of the Rental Housing Support Program for affordable housing developments. The goal of the LTOS program is to increase the supply of affordable housing to households earning at or less than 30% of Median Income by providing a long term, unit based, rent subsidy. LTOS grants are awarded in response to a competitive program application. Funding under the LTOS Program is generally targeted for supportive housing and special needs populations. *Colbert* Class Members seeking rental of LTOS units will need to apply and meet eligibility, tenant selection, and wait list criteria.

G.7. Low Income Housing Tax Credits (LIHTC)

Illinois Housing Development Authority (IHDA) administers Low Income Housing Tax Credits (LIHTC), which are a primary source for housing production. IHDA makes LIHTC awards on the basis of a point system included within its Qualified Allocation Plan (QAP). During the last four years, IHDA has made several amendments to its QAP to grant specific points for tax credit proposals that house persons with disabilities in a community-integrated setting. Developers that agree to set aside between 10% and 20% of their LIHTC units for persons with disabilities, or who are experiencing or are at risk of homelessness and have incomes below 30% of AMI receive substantial points for making this voluntary election.

G.8. Build Illinois Bond Program (BIBP)

The BIBP was created after IHDA was allocated $130 million in Illinois general obligation bond funding as part of the ILLINOIS JOBS NOW program. The legislation directs IHDA to use a minimum of $30 million of the total for supportive housing. IHDA decided to use roughly $75 million of the funds for supportive housing. Since 2010 IHDA has had 3 competitive Requests for Applications and has allocated the entire $75 million. This program marks the first time in Illinois history that capital bonds have been used to finance the creation of affordable housing.

H. Accessible Housing

Colbert Class Members with disabilities require accommodations with accessible features that address their needs. Accessible housing refers to the physical design as well as accessibility features such as modified furniture, shelves and cupboards, or even electronic devices in the home that enable independent living for persons with disabilities. IDoA is actively working with Public Housing Authorities in the City of Chicago and Cook County, private property owners and developers to identify existing accessible units as well as adaptable units that can be easily modified. The Home First Illinois initiative has provided accessible units dedicated to *Colbert* Class Members and IDoA has entered into contract with the University of Illinois in Chicago's Assistive Technology Unit to assist with modification requests.

H.1. Assistive Technology/Home Modification

The University of Illinois at Chicago Assistive Technology Unit (UIC-ATU) will provide assistive technology and accessibility modifications in most cases upon the recommendation of the MCO Care Coordinator. In some cases, MCO, HSA or CMHC staff may refer a Class Member to the UIC-ATU once the Class Member has moved and determined that the Class Member requires additional support or home modifications. An Occupational and Physical Therapist will assess the Class Member's physical disability, make recommendations, and develop an individualized service plan that focuses on assistive technology and accessibility modifications to support the transition in the selected housing unit. These professionals were selected to provide a more thorough assessment of the needs of physically disabled *Colbert* Class members and to provide additional opportunities to support independent living.

Based on the outcome of the assessment, recommendations will be made regarding accessibility changes necessary for the Class Member to function in the community-based setting, such as, entry/ exit changes, alterations to allow movement within the unit, transfers

and bathroom modifications. The assessment will enable the Class Member's accessibility requirements to be matched with appropriate housing stock, if available. This information will be shared with the HSAs as they search for housing for the Colbert Class Member. When accessible housing is not available and modifications are required, the UIC team will design the modifications, and manage the construction process. The Consent Decree allows for a onetime payment of allowable expenses not to exceed $5000 per Class Member to make a Community Based Setting accessible for a Class Member. Additionally, IDoA will explore the use of DRS funding when the Class Member is less than 60 years of age. DRS provides a maximum of $25000 for each qualified Class Member that can be used over a five year period. The UIC-ATU recommendations will be documented and maintained in the Class Member's file.

Additionally, recommendations will be made for assistive technology equipment related to tasks such as food transport, meal preparation, cooking, eating, general housekeeping, specialized seating, and communication devices.

The UIC-ATU will deliver any recommended equipment and train the Class Member regarding its use. UIC-ATU staff will perform and document up to three (3) follow-up telephone calls post-transition to confirm successful usage of the Assistive Technology and Accessibility equipment. An in-person visit will be provided if necessary.

The UIC-ATU will also develop a series of on-line training modules that will be made available to MCO, housing specialist and CMHC staff regarding typical accessibility issues encountered by individuals with disabilities regarding access to or within Community-Based Settings. The UIC-ATU will host a monthly online discussion of Class Member cases, highlighting the issues identified during the Evaluations, and assistive technology and accessibility modifications recommended and provided. Data regarding the effectiveness, trends and patterns produced by these assessments and recommended interventions will be collected for reporting and analysis.

I. Housing Development Strategies

IDoA aims to develop stronger collaboration with private developers to create more supportive housing options for Consent Decree Class Members. A number of initiatives are underway to provide funding and support to developers requests for participation or expressing an interest in participating.

J. Quality

Quality is at the core of the State's vision for *Colbert* Class Members' services. To the extent practical, it is the State's goal to standardize quality improvement strategies across all of the Olmstead consent decrees (*Colbert*, *Williams* and *Ligas*) as well as for the Money Follows the Person Demonstration Project and the 1915(c) Home and Community based Services (HCBS) Waivers under the Social Security Act. This is consistent with State policy direction introduced in the proposed state delivery system innovation plan, the Alliance for Health, and the 1115 Waiver application recently submitted to the Centers for Medicare and Medicaid Services (CMS). In the Waiver application, the State seeks to combine its current waiver populations to

include persons with behavioral disorders within one waiver, assuring that services are allocated to each individual, based on functional need. Integrating a corollary quality improvement strategy is a necessary next step.

Concurrent with the filing of the 1115 Waiver in June, 2014, the GOHIT is convening five stakeholder workgroups to develop a detailed implementation strategy. These groups will be co-led by a member of the Governor's Office and an important community leader with expertise in the subject matter and supported by nationally recognized subject matter experts (SME). The Services and Supports Work Group, specifically, will address Continuous Quality Improvement (CQI) for all Long Term Services and Supports, with a focus on the waiver population. It is expected that final recommendations from these groups shall be available by early 2015.

While an integrated CQI process is under development through the Work Group process, specific interim enhancements to the current CQI process for *Colbert* Consent Decree implementation will be initiated. These include enhancements to the Critical Incident Management Protocol, including Mortality Reviews and the initiation of a Peer Advisory Council.

J.1. Continuous Quality Improvement/ Data Collection, Tracking and Reporting

The State is committed to establishing a system of data collection, tracking and reporting as a means for establishing quality as on ongoing process and goal. The focus will be on evaluating system effectiveness in meeting the goals of delivering positive outcomes for *Colbert* Class Members and measures will focus on process as well as clinical outcomes. Based largely on the DDRI (Design, Discovery, Remediation and Improvement) model endorsed by the Centers for Medicare and Medicaid, the State will establish a set of performance measures that will assess quality and identify priorities for intervention and determine how data will be collected. Data sources may include but are not limited to claims data and data currently captured by the Transition Coordinators, Housing Specialists, and providers (Design). Using the performance measures, data will be reviewed and analyzed (Discovery). Findings will be forwarded to program staff and Directors for correction action (Remediation), and Quality Improvement (Improvement) is anticipated through implementation of long-term systemic solutions to the underlying problems discovered. Additional use of data is required to measure success.

In addition to reviewing data by program staff, the State will convene a Quality Improvement Committee. This Committee, comprised of consumers, state staff and key system stakeholders, will review data from a wide range of sources from the CQI process to recommend systemic changes to improve service delivery, client outcome and satisfaction.

J.2. Incident Management

Colbert Consent Decree MCO Care Coordinators and the CMHC staff for *Colbert* Class Members with SMI will be held accountable for reporting critical and reportable incidents, using standardized forms and parallel procedures. A newly developed Incident Reporting Form requires the MCO Care Coordinator/CMHC staff to classify the incident into one of three

distinct levels: Level 1 - Urgent/Critical; Level II – Serious/Reportable; Level III-Significant/Reportable. All Level I and II incidents will precipitate an investigation and a required staffing to be held by the MCO Care Coordinator, CMHC staff and a *Colbert* designee. A report on the investigation with a corrective action plan is submitted to the Agency(s) within ten (10) business days. For Level III incidents, staffings will occur at the discretion of the *Colbert* Director or designee. Risk mitigation plans are also reviewed and modified as appropriate by the MCO Care Coordinators and CMHC staff and all cases are reviewed for follow up by the staffing team within 30 days. All incidents are reported to and tracked by the *Colbert* Director or designees. *Colbert* Consent Decree data will be documented for review and aggregation.

As Class Members' tenure in the community exceeds 12 months and the Transition Coordination function currently provided by Aetna Better Healthcare, Inc. and IlliniCare Healthplan ceases, these procedures will no longer be operative. The Managed Care Entities responsible for the medical care of the *Colbert* Class Members are contractually obligated to create internal processes for Incident Management. State accountability for quality performance is quantified by performance metrics established in contract. CMHCs will continue to adhere to the above procedures for the term of the *Colbert* Consent Decree.

J.3. Mortality Review

Deaths from all causes are reported on the Incident Reporting Form and followed up with calls to designated staff within each Department and the Governor's Office. In addition, the University of Illinois, College of Nursing (UIC), currently serving as the designated state authority for mortality reviews for the Money Follows the Person Demonstration Project, will take on the responsibility of reviewing all mortalities of all *Colbert* and *Williams* Class Members. Once notified of a death, the UIC Mortality Review team will conduct an interview with the Transition Coordinator or Quality Administrator (*Williams*) who will compile all pertinent information for review and consideration by the team. UIC determines if a root cause analysis (RCA) is appropriate, generally basing that finding on whether the death was the result of natural causes. For example, in most cases other than expected deaths due to natural causes, a RCA is indicated. UIC subsequently collects additional clinical records, reviews medical claims data, reviews autopsy findings, when available, and may conduct additional interviews. RCA findings are submitted to the Departments and corrective action is reviewed and monitored by the *Colbert*/*Williams* Directors or designees.

The State will initiate a Mortality Review Committee to review all deaths of Class Members of both Consent Decrees. Mortality review data, collected through the above delineated process, will be analyzed by a cross-division, multidisciplinary group of healthcare and quality professionals knowledgeable about the population and systems under review. The process is designed to evaluate trends that may reflect a need for improvements to aspects of the service delivery and quality oversight systems. Findings are shared with Department staff members charged with program management and the *Colbert*/*Williams* Directors.

J.4. Consumer Input and Engagement

Key to the success of any service delivery system is the ability to demonstrate positive outcomes for those individuals receiving care in the system. Methods for investigating consumer "perception" of care become central strategies to a quality improvement methodology. In the *Colbert* Consent Decree implementation, the State will conduct Quality of Life Surveys as well as create a Peer Advisory Council for ongoing input on ways to strengthen the system for others choosing to move to the community.

J.5. Quality of Life Survey

Quality of Life surveys are conducted in accordance with MFP guidelines for all *Colbert* Class Members pre-discharge, and at eleven (11) months and twenty-four (24) months post-discharge to discern the Class Members' perceptions relating to quality of life while still living in the Nursing Facility and then in the Community-Based Setting. Class Members' perceptions of quality of life are queried in seven domains: living situation, choice and control, access to personal care, respect/dignity, community integration/inclusion, overall life satisfaction and health status.

J.6. Complaints and Grievances

IDoA defines a complaint as a formal expression (verbal or written) of dissatisfaction expressed by a Class Member, a designated representative of the Class Member, or a State contracted provider of services. A grievance is defined as a verbal or written expression of dissatisfaction concerning a violation of written rights, rules, statutes or State contract terms, such as those defined in the Health Insurance Portability and Accountability Act (HIPAA), the States Administrative Rules, State contracts, the Illinois Mental Health and Developmental Disabilities Code and the Mental Health and Developmental Disabilities Confidentiality Act. *Colbert* Class Members will be informed of their right to file a complaint or grievance and the process involved, in Colbert Outreach materials distributed by MCO Care Coordinators, Engagement Specialists, CMHC staff and HSA staff as well as on a fact sheet displayed on the Colbert webpage.

Allegations of abuse and neglect are considered serious and must be reported to the appropriate authority. For persons living in Nursing Facilities, complaints must be directed to the Department of Public Health; for individual living in the community, complaints must be directed to the 24-hour Adult Protective Services Hotline at IDoA at 1-866-800-1409. Providers and consumers will receive ongoing training on all reporting requirements and procedures in cases of suspected abuse or neglect.

J.7. Appeals

Colbert Class Members will be informed of their right to appeal decisions made during the implementation process initially through an informal review process administered by IDoA staff. A Class Members' right to grieve is included as part of the outreach materials and a fact sheet on the *Colbert* webpage. If the Class Member disputes the decision made through the informal review process, he or she will be given notice of appeals through existing HFS fair hearing processes. Timeframes for requesting hearings through this process will only begin after the conclusion of the informal review process.

J.8. Peer Advisory Council

The *Colbert* Peer Advisory Council is being created in response to our belief that *Colbert* Class Members are valuable consultants regarding this process and the keen interest that has been expressed by many of them. The *Colbert* Peer Advisory Council will meet quarterly effective September 2014. This council will provide ongoing consultation and advice to the Defendants, Monitor, and Parties regarding implementation of *Colbert* activities from the perspective of Class Members and their families. Members of the Peer Advisory Council will be selected by the Defendants with input from the Parties. The Defendants will provide administrative support to the Council and when necessary reimburse approved costs associated with Class Member travel. Summaries of Council meetings and any written recommendations will be included in semi-annual reports.

K. Contract Performance Monitoring

Beginning in July 2015, IDoA has negotiated new contracts with AgeOptions and the City of Chicago Department of Family Supports to continue their outreach and education services and to establish and manage a Peer Mentoring program for *Colbert* Class Members. IDoA has also negotiated housing specialist contracts with Access Living, Featherfist, Heartland Human Care Services with new incentive rates to expedite the identification and transition services for *Colbert* Class Members and DMH-contracted community mental health centers (Thresholds, Trilogy, Inc., Community Counseling Center of Chicago, Association House, Grand Prairie Services, Heartland, Sertoma Center, Pilsen Wellness Center and the Kenneth Young Center). Contract negotiation with the two managed care companies, Aetna and IlliniCare for Phase Two of the Implementation Plan will begin during the first quarter of the fiscal year as the contracts expire in November 2014.

K.1. Outreach Contract Performance Monitoring

IDoA staff will review activity reports submitted monthly by Age Options and CDFSS to monitor compliance with contract deliverables. Reports will include the names of the Nursing Facilities that were visited, the types of engagement activities that were conducted and the number of *Colbert* Class Members that have been engaged. Age Options and CDFSS will also report on the number of peer mentors that were recruited and participated in individual and small group information groups. IDoA staff will meet with agency staff by telephone at least monthly. Outreach contractor records will be audited at least annually. At that time, *Colbert* Class Member engagement records will be reviewed for quality and consistency with monthly reports, and Transition Engagement Specialist credentials will be reviewed for contractual compliance.

K.2. Managed Care Contract Performance Monitoring

IDoA has dedicated a full-time staff position titled Managed Care Contract Liaison to act as a liaison for the management and monitoring of the IDoA/Managed Care Organization contracts for the Evaluation, service plan development, post-transition monitoring and care coordination of *Colbert* Class Members. Audit activities will include: (1) sampling of completed Evaluations

for quality and completeness in accordance with best practices; (2) review of Qualified Professional credentials for compliance with contractual requirements; (3) review of *Colbert* Consent Decree Evaluation Procedures; (4) review of Evaluation Disposition data for trends and patterns; (5) sampling of completed Service Plans of Care and Social Histories for quality and completeness in accordance with best practices; (6) review of Service Plan of Care development procedures; 7) review of service delivery for appropriateness and consistency with Service Plan of Care; (8) review of Service Plan of Care data for trends and patterns; (9) Qualified Professional training records; and (10) review of 24-Hour Back-up Plans and Risk Mitigation Plans for quality and completeness.

A transition compensation structure consistent with performance outcomes will be addressed as part of the Fiscal Year 2015 contract negotiation process.

K.3. Housing Specialist/CMHC Performance Monitoring

IDoA and DMH will jointly monitor the performance of the CMHCs and IDoA will monitor the performance of the HSAs to identify inconsistencies and areas for improvement. Site visits will be conducted annually to audit files and review the implementation of *Colbert* housing policies and procedures. IDoA staff will accompany selected housing location and CMHC staff to monitor: unit viewings with Class Members; pre-inspections; lease negotiations; and move-ins. The transition compensation structures will be consistent with performance outcomes for both the CMHCs and the HSAs.

L. Rebalancing Training Institute

The on-going provision of long-term care services to persons with disabilities in the most integrated Community-Based Settings is a major paradigm shift in Illinois' long-term care service delivery system. To successfully implement this change and rebalance the provision of long-term care services so that more persons with disabilities receive services in Community-Based Settings rather than institutional settings will require a workforce with requisite skill sets. The State will begin work to meet this need by developing a Rebalancing Training Institute for use by providers associated with the implementations of the Olmstead Class Actions. The purpose of the Rebalancing Training Institute will be to provide the training, resources and technical assistance necessary to enhance the skill sets of the many providers engaged in these efforts. Additionally, the Institute will standardize training on certain topics in an attempt to promote consistent language, definitions and protocols among contractors and caregivers. Topics will cover a wide range of subjects including Consent Decree operational protocols, relevant statutes, and best practices in community reintegration.

The Rebalancing Training Institute model will meet the training needs of providers associated with rebalancing long-term care in Illinois by engaging the services of subject matter experts, both local and national. Training will be provided through multiple venues, i.e., in person, by teleconference or webinar. Training frequency will vary. The Rebalancing Training Institute will address workforce turnover by repeating certain topics and present newly emerging issues in a timely manner so as to keep the workforce informed.

State contractors such as the Housing Specialists, MCO Care Coordinators and Transition Specialists noted in this Plan will avail themselves of the resources offered at the Institute as well as direct providers. In some cases, providers will arrange their own training and simply be required to submit the trainer name and credentials along with learning material outlines. Other topics will require direct training through the Institute. In most cases, the train-the-trainer model will be used when direct training is indicated.

In addition to the training provided by the Rebalancing Training Institute, IDoA will provide technical assistance and resources, when necessary, to assist *Colbert* contractors with providing the training. Additionally, training will be offered as needed regarding *Colbert* Consent Decree Implementation operational protocols, relevant statutes and best practices in community reintegration. *Colbert* contractors are responsible to have procedures in place to train and supervise their staff. In addition, contracted agencies are required to provide annual plans. The Rebalancing Training Institute will prioritize training needs among the Consent Decree providers and initiate training efforts this Fiscal Year. Summaries of provider protocols for training can be found in Appendix D.

M. *Colbert* Class Member Transition Tracking System

IDoA is developing a management information system, "*Colbert* Class Member Transition Tracking System", with objectives, an approach, current progress and future directions as described below.

The objective of the Transition Tracking System is threefold: to effectively track *Colbert* Class Members through the transition process from Nursing Facilities to housing in the community; to provide a technology platform for all the responsible parties, such as IDoA, MCOs, CMHCs and HSAs to facilitate effective and efficient communication and collaboration, and to collect and process accurate data for process monitoring, statistical analysis and strategic decision support reporting.

M.1. Approach

Historical transition progress data from various electronic documents as obtained from the MCOs and Housing Specialists will initially be uploaded or keyed into the new system database. Current referral data from Illinois Department of Healthcare and Family Services (HFS) Money Follows the Person (MFP) will then be uploaded into the system database on a daily or twice-weekly basis by IDoA staff.

The MCOs will be responsible for entering Contact Attempts and Evaluation Dispositions data for each referral as it moves through the process. Once a recommendation for housing of a Class Member is processed by HFS, the MCO Care Coordinator will be responsible for creating a housing referral for the appropriate HSA or CMHC. Upon receiving housing referrals, the assigned Housing Specialists will then be responsible for entering housing related data into the system for each transition-related event. MCOs will be responsible for recording post transition events, such as scheduled follow-ups and critical incidents.

Several process monitoring, progress tracking and statistical analysis reports will be generated by the system. Data integrity and entry checks and business rules based constraints are built into the system to ensure high quality data for accurate reporting.

IDoA IT staff are currently working on the initial upload of historical transition progress data and the regular upload of current referral data from HFS/MFP.

IDoA are currently testing the system software code and will begin to perform thorough technical and functional testing. Upon the completion of testing and acceptance of the code, the system will be rolled out to production as a secure internet based web application available to only authenticated and authorized users. All identified users will be trained for proper usage of the system. IDoA will be responsible for on-going support and technical assistance. Further planning and development will be conducted immediately after the initial implementation to extend the functionality and improve the utility of the system.

N. Budget

Fiscal Year 2015

The Fiscal Year 2015 budget passed by the General Assembly for implementing the *Colbert* Decree was the same amount as introduced by the Governor's "recommended budget, but IDoA and DHS budgets were significantly reduced by the Illinois General Assembly. This latter legislative action notwithstanding, the Governor remains fully committed to his “rebalancing efforts” and to meeting the requirements of the Consent Decree. In the IDoA FY2015 enacted budget, $32,496,400 is designated to be used for Colbert Consent Decree implementation.

Colbert Consent Decree Implementation Plan Work Plan

This work plan is an internal management tool for use by IDoA and the State in Colbert Implementation. The work plan is an evolving document that the State may modify to address developments and issues with the goal of improving performance and increasing efficiency.

Appendix A – MCO Tasks Work Plan

MCO TASKS	PARTY RESPONSIBLE	DATE DUE	MONITORED BY	MONITORING FREQUENCY
Teams of Qualified Professionals shall be retained that include a Health Care Professional, a Behavioral Health Specialist and a Care Coordinator in accordance with contractual requirements.	MCO	Initial teams confirmed July, 2014	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
Care Coordinators are to be assigned so that the CM has the same Care Coordinator during Evaluation, Service Plan of Care, transition and post-transition.	MCO	Initial assignments confirmed July, 2014.	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
Sufficient Care Coordinators shall be retained to limit the caseload of each Care Coordinator to a maximum of 15 Class Members in the transition process and 50 Class Members in the community.	MCO	Full staffing confirmed b July, 2014	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
Protocols are to be in place for retaining, training, and supervising members of the multi-disciplinary teams providing services to Colbert Class Members.	MCO	Protocols confirmed by July 2014.	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
Sufficient staff shall be retained and operations will be conducted in a way that is calculated to meet the transition targets in the Consent Decree.	MCO	Full staffing confirmed by July 2014.	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
Upon referral, evaluations shall be conducted that include a chart review, a face to face interview with the CM and interviews with family members, friends and nursing home staff as needed. Evaluations conducted within 14 days after referral.	Multi-disciplinary team	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
Within 7 days after an evaluation, the multi-disciplinary team shall meet to identify those Class Members who are candidates for transition.	Multi-disciplinary team	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
The multi-disciplinary team shall meet to identify what those CMs who do not appear to be immediate candidates for transition can do to prepare for transition.	Multi-disciplinary team	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly

Appendix A – MCO Tasks Work Plan

MCO TASKS	PARTY RESPONSIBLE	DATE DUE	MONITORED BY	MONITORING FREQUENCY
If transition is recommended, the MCO Coordinator will prepare, within 7 days after recommendation, the Service Plan of Care and Social History as defined in the contract. MCO Coordinator will then determine if a referral to a CMHC or ATU is warranted and make the referral. Sufficient staff shall be retained and operations will be conducted in a way that is calculated to meet the transition targets in the Consent Decree.	Multi-disciplinary team	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
If transition is recommended and the CM refuses to consent to the preparation of Social History and Service Plan of Care the Care Coordinator shall attempt to obtain and document an explanation for the CMs refusal.	Multi-disciplinary team	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
If transition is not recommended, the Care Coordinator, within 7 days after the determination, shall have a face-to-face conversation with the CM and others that the CM would like to be present to explain the concerns raised by the multi-disciplinary team and to further determine if the CM's needs can be addressed in the community.	Multi-disciplinary team	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
If transition is still not recommended the multi-disciplinary team shall document, within 7 days after the determination, the bases for the recommendation, document any plans for follow-up.	MCO	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
If transition is not recommended, the Care Coordinator, within 7 days after the determination, must explain the Class Member's rights to re-open the evaluation.	MCO	Full staffing confirmed by July, 2014.	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
The Class Member or any legal guardian shall be given written information that summarizes Class Members' appeal rights.	Multi-disciplinary team	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
The Service Plan of Care completed by the MCO Care Coordinator shall include a risk mitigation plan.	Multi-disciplinary team	Ongoing	Quality/Compliance Liaison MCO Contract	Quarterly

Appendix A – MCO Tasks Work Plan

MCO TASKS	PARTY RESPONSIBLE	DATE DUE	MONITORED BY	MONITORING FREQUENCY
			Monitor	
The Service Plan of Care shall include a 24 hour 7 day a week back-up plan.	Multi-disciplinary team	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
The MCO designee shall administer the initial MFP Quality of Life survey at least 2 weeks before discharge from the nursing facility.	MCO	Full staffing confirmed by July, 2014.	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
The MCO team, within 7 days after a recommendation for transition, will refer the Class Member who is diagnosed with a serious mental illness and who requires community mental health services to a community mental health center for transition to the community and appropriate community mental health services.	Multi-disciplinary team	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
The MCO team, within 30 days after a recommendation for transition, will refer the Class Member who has physical disabilities and may require home modifications to Access Living for housing location and transition services.	MCO	Protocols confirmed by July 2014.	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
The MCO team, within 30 days after a recommendation for transition, will refer other Class Members who do not require mental health services to Featherfist or Heartland for housing location and transition services dependent upon the preferred geographic area.	MCO	Full staffing confirmed by July, 2014.	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
The Service Plan of Care shall reflect timely identification and assignment to appropriate HCBS Waiver Services where the CM has been determined eligible and agrees to participate in the waiver program.	Multi-disciplinary team	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
The Service Plan of Care shall reflect, where, applicable identification and timely access to appropriate DASA services	Multi-disciplinary	Ongoing	Quality/Compliance Liaison	Quarterly

Appendix A – MCO Tasks Work Plan

MCO TASKS	PARTY RESPONSIBLE	DATE DUE	MONITORED BY	MONITORING FREQUENCY
where the Class Member has been determined eligible and agrees to participate.	team		MCO Contract Monitor	
The Service Plan of Care shall reflect timely identification and assignment to appropriate Home Services Waiver Services where the CM has been determined eligible and agrees to participate in the waiver program.	Multi-disciplinary team	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
The Service Plan of Care shall reflect verification of availability of medication, appropriate food, housing, furnishings, assistive technology, environmental modifications, and identification of transition costs, housing assistance and any housing subsidies.	Multi-disciplinary team	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
The Service Plan of Care shall include verification that Durable Medical Equipment (DME) is present at the time of transition.	Multi-disciplinary team	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
The Service Plan of Care shall assure that there are no gaps in service and or supports.	Multi-disciplinary team	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
The MCO team, within 7 days after a recommendation for transition, shall refer any Class Member that has physical disabilities to UIC-ATU for an evaluation of his physical disabilities and mobility limitations for assistive technology and or home modifications.	Multi-disciplinary team	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
The MCO team shall assist the assigned housing locator with moving the Class Member from the nursing facility to the community-based setting.	Multi-disciplinary team	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
After transition to community-based setting, the Care Coordinator shall provide comprehensive care	Care Coordinator	Ongoing	Quality/Compliance Liaison MCO Contract	Quarterly

Appendix A – MCO Tasks Work Plan

MCO TASKS	PARTY RESPONSIBLE	DATE DUE	MONITORED BY	MONITORING FREQUENCY
coordination services to ensure that Class Member needs are identified and are met through referrals for all available services for which the CM is eligible.			Monitor	
If the CM is enrolled in an MCE other than the Colbert MCO's separate Integrated Care Program contract, the Colbert Care Coordinator will continue to provide comprehensive care coordination services as stated above.	Care Coordinator	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
In the first month post-transition, the Care Coordinator will meet face to face with the Class Member once a week, or more often as needed.	Care Coordinator	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
In the first month post-transition the Care Coordinator will contact the person identified in the Service Plan of Care as a contact for CM or, as needed, service providers, by telephone twice a week, or more often as needed.	Care Coordinator	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
In the second month post-transition the Care Coordinator will make contact with the Class Member as needed.	Care Coordinator	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
In the second month post-transition, the Care Coordinator will contact the person identified in the Service Plan of Care as a contact for the CM or the service providers by telephone once a week, or more often as needed.	Care Coordinator	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
In the third through twelfth month post transition, the Care Coordinator will contact the Class Member either in person or via telephone and/or the person identified in the Service Plan of Care as a contact for the Class Member as needed.	Care Coordinator	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly

Appendix A – MCO Tasks Work Plan

MCO TASKS	PARTY RESPONSIBLE	DATE DUE	MONITORED BY	MONITORING FREQUENCY
The MCO team shall submit, as required, critical incident report whenever a critical incident and submit the plan for addressing the critical incident.	Care Coordinator	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly

Appendix A - Quality Tasks Work Plan

QUALITY TASKS	PARTY RESPONSIBLE	DATE DUE	MONITORED BY	MONITORING FREQUENCY
Establish a set of quality measures for assessing Colbert Consent Decree implementation.	Quality/Compliance Liaison	September 1, 2014	Colbert Project Director	One-time
Review and assess data using quality measures.	Quality/Compliance Liaison	December 1, 2014	Colbert Project Director	One-time
Use findings for corrective action and implementation of long-term systemic solutions.	State Agency Directors Colbert Project Director	December 1, 2014	Governor's Office	Quarterly
Report critical incidents involving Colbert Class Members.	Care Coordinator Community Mental Health Worker	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Ongoing
Negotiate contract with UIC to review mortalities of all Colbert Consent Decree participants.	Governor's Office	September 1, 2014	Governor's Office	One-time
Initiate a Mortality Review Committee.	Governor's Office	September 1, 2014	Governor's Office	Annually
Conduct Quality of Life Surveys at 2 to 4 weeks before discharge from the nursing facility.	Care Coordinator Community Mental Health Worker	Ongoing	Quality/Compliance Liaison MCO Contract Monitor	Quarterly
Inform Class Members of complaint, grievance and appeal process	Care Coordinator	Ongoing	Quality/Compliance Liaison MCO Contract Monitor Outreach Contract Monitor	Quarterly
Create Peer Advisory Council.	Quality/Compliance Liaison	October 1, 2014	Colbert Project Director	One-time

Appendix A - Housing Locator Tasks Work Plan

HOUSING LOCATOR TASKS	PARTY RESPONSIBLE	DATE DUE	MONITORED BY	MONITORING FREQUENCY
Develop and maintain a current list of housing options identifying rental properties throughout Cook County.	Housing Locator Agency	Initial list completed by August 31st, 2014	Transition & Research Administrator Housing Coordinator	Quarterly
Conduct intake with Class Members to establish housing needs and barriers within 7 days of referral.	Housing Locator Agency	Ongoing	Transition & Research Administrator Housing Coordinator	Weekly
Accompany Class Member on site visits to properties in geographic areas of the Class Member's choice within 30 days of intake.	Housing Locator Agency	Ongoing	Transition & Research Administrator Housing Coordinator	Weekly
Provide or arrange transportation to site visits at the expense of the Class Member.	Housing Locator Agency	Ongoing	Transition & Research Administrator Housing Coordinator	Quarterly
Assist the Class Member with the application process.	Housing Locator Agency	Ongoing	Transition & Research Administrator Housing Coordinator	Weekly
Submit request to HACC for inspection and rent reasonableness within 24 hours of application approval.	Housing Locator Agency	Ongoing	Transition & Research Administrator Housing Coordinator	Daily
Facilitate the execution of the lease and the completion of the HAP agreement within 2 days of passed inspection and approved rental amount.	Housing Locator Agency The Housing Authority of Cook County (HACC)	Ongoing	Transition & Research Administrator Housing Coordinator	Daily
Request and manage Class Members' transition funds to purchase necessary household items.	Housing Locator Agency	Ongoing	Transition & Research Administrator Housing Coordinator	Daily

Appendix A - Housing Locator Tasks Work Plan

HOUSING LOCATOR TASKS	PARTY RESPONSIBLE	DATE DUE	MONITORED BY	MONITORING FREQUENCY
Move Class Member into unit within 8 weeks of date of referral.	Housing Locator Agency	Ongoing	Transition & Research Administrator Housing Coordinator	Quarterly
Produce receipts for all items purchased with transition funds and submit to HACC for each Class Member within 30 days of Class Member move-in.	Housing Locator Agency	Ongoing	Transition & Research Administrator Housing Coordinator	Weekly

Appendix A - Outreach Tasks Work Plan

OUTREACH TASKS	PARTY RESPONSIBLE	DATE DUE	MONITORED BY	MONITORING FREQUENCY
Transition Engagement Specialists to travel to each nursing facility within their respective areas during the fiscal year.	Transition Engagement Specialist	All facilities visited at least once by June, 2015.	Outreach Contract Monitor	Quarterly
Transition Engagement Specialists to provide outreach at nursing facilities and document individual and small group contacts.	Transition Engagement Specialist	Ongoing	Outreach Contract Monitor	Quarterly
Transition Engagement Specialists to refer and assist CMs for transition through the MFP web application.	Transition Engagement Specialist	Ongoing	Outreach Contract Monitor	Monthly
Transition Engagement Specialists to document educating nursing facility staff regarding the Colbert Consent Decree, MFP and other community-based alternatives to institutional care.	Transition Engagement Specialist	Ongoing	Outreach Contract Monitor	Quarterly
Agency to submit description of peer mentoring program to IDoA.	Agency Staff	July 15, 2014	Colbert Project Director	One-time
Agency to implement Peer Mentoring program.	Agency Staff	September 1, 2014	Colbert Project Director	One-Time
Peer Mentors to be trained to assist Transition Engagement Specialists as they conduct small group and individual engagement and information sessions.	Outreach Contract Monitor	Ongoing	Outreach Contract Monitor	Quarterly
Peer Mentors should assist Transition Engagement Specialists as they conduct small group and individual engagement and information sessions.	Outreach Contract Monitor	Ongoing	Outreach Contract Monitor	Quarterly
Develop written informational materials to inform and educate Colbert Class Members regarding their rights.	Outreach Contract Monitor	Ongoing	Quality/Compliance Liaison	One-time and as needed
Monitor and Document queries on Colbert Informational Email.	Outreach Contract Monitor	Ongoing	Quality/Compliance Liaison	Quarterly

Appendix A - Outreach Tasks Work Plan

OUTREACH TASKS	PARTY RESPONSIBLE	DATE DUE	MONITORED BY	MONITORING FREQUENCY
Respond to queries on Colbert Informational Email within 2 business days.	Outreach Contract Monitor	Ongoing	Quality/Compliance Liaison	Quarterly
Provide Colbert informational telephone line for use by Colbert Class Members, families, and interested parties.	Aging Staff	Ongoing	Quality/Compliance Liaison	One-time
Receive and document queries on informational line.	Senior Help Line	September 1, 2014	Outreach Contract Monitor	Monthly

Appendix A - Subsidy Administrator Tasks Work Plan

SUBSIDY ADMINISTRATOR TASKS	PARTY RESPONSIBLE	DATE DUE	MONITORED BY	MONITORING FREQUENCY
Develop and maintain a current list of all Class Members referred for transition and housing assistance with outcomes.	The Housing Authority of Cook County (HACC)	Initial list confirmed by July, 2014	Transition & Research Administrator Housing Coordinator	Weekly
Schedule HQS inspections for all units that will receive a Bridge Subsidy within 3 days of request.	The Housing Authority of Cook County (HACC)	Ongoing	Transition & Research Administrator Housing Coordinator	Daily
Ensure all rents are within the Fair Market Rent or Local Payment Standard for the area within 24 hours of the approved inspection.	The Housing Authority of Cook County (HACC)	Ongoing	Transition & Research Administrator Housing Coordinator	Daily
Calculate utility allowances for units.	The Housing Authority of Cook County (HACC)	Ongoing	Transition & Research Administrator Housing Coordinator	Daily
Facilitate the execution of the lease and the completion of the HAP agreement within two (2) days of unit approval.	The Housing Authority of Cook County (HACC) Housing Locator Agency	Ongoing	Transition & Research Administrator Housing Coordinator	Daily
Process Class Members' transition funds to purchase necessary household items within 24 hours of fund approval.	The Housing Authority of Cook County (HACC) Transition & Research Administrator Housing Coordinator	Ongoing	Transition & Research Administrator Housing Coordinator	Daily
Receive and process reconciliation of receipts for all items purchased with transition funds for each Class Member within 30 days of Class Member move-in.	The Housing Authority of Cook County (HACC)	Ongoing	Transition & Research Administrator Housing Coordinator	Monthly

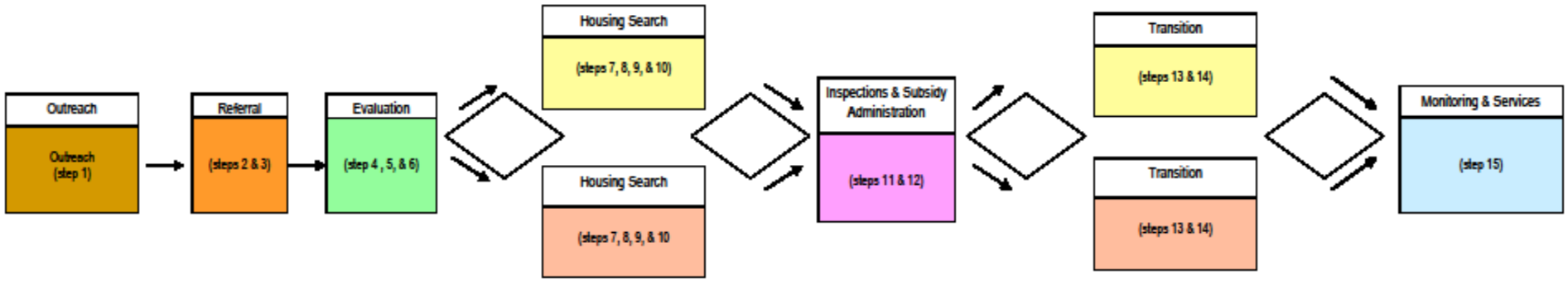
Appendix A - Subsidy Administrator Tasks Work Plan

SUBSIDY ADMINISTRATOR TASKS	PARTY RESPONSIBLE	DATE DUE	MONITORED BY	MONITORING FREQUENCY
Assess relevant households for Section 8 within 6 months of transition.	The Housing Authority of Cook County (HACC) Transition & Research Administrator Housing Coordinator	Ongoing	Transition & Research Administrator Housing Coordinator	Quarterly
Produce detailed reports of all transition and subsidy expenditures.	The Housing Authority of Cook County (HACC)	Ongoing	Transition & Research Administrator Housing Coordinator	Quarterly

Appendix B—Flowchart of the Colbert Transition Process

Tasks & Responsible Parties

ADRC/ADRN	MFP	MCO	Housing Specs. / CMHC	HACC	Housing / CMHC	MCO / CMHC
1. ADRC/ADRN will visit all 185 nursing facilities to provide education to the Class Members on the Colbert Consent Decree, explaining the various housing options and the financial and supportive services available to them	2. Referrals received online via the MFP WebApp will be processed for evaluation 3. Referral made to MCO for evaluation and initial contact will be made within 10 business days	4. Evaluate interested Class Members for appropriateness for transition 5. Complete Service Plan of Care 6. Refer Class Members to Housing Spec. or CMHC	7. Housing Specs. or CMHCs conduct intake with Class Members to establish housing needs and barriers 8. Accompany Class Members on a minimum of 3 site visits to properties 9. Assist the Class Member with the application process 10. Submit request for HQS inspection & transition funds	11. HACC schedule HQS inspections for Bridge subsidized units and ensure rents are within Fair Market Rent or Local Payment Standards 12. Facilitate execution of lease and completion of the HAP agreement within 2 days of unit approval, and process transition funds within 24 hours of unit approval	13. Housing Specs. or CMHCs purchase and set up furniture and other household items 14. Purchase groceries and move Class Member into approved unit	15. MCOs or CMHCs monitor Class Member adjustment to transition and service provision



Ongoing Activity

Illinois Department on Aging	The Housing Authority of Cook County	MCO / CMHC
A. The Department on Aging Office of Transitions and Community Relations will provide training and ensure resources are available to all responsible parties B. All activities will be monitored regularly and data collected via the Colbert Data System	A. The HACC will receive and process reconciliation of receipts for all items purchased with transition funds B. Assess relevant households for Section 8 C. Produce detailed reports of all transition and subsidy expenditures	A. MCOs and CMHCs will monitor the Class Member post-transition and ensure that necessary services are provided

Responsible Parties Key:
- Action by ADRC/ADRN
- Action by MFP
- Action by Managed Care Organization
- Action by Housing Specialist
- Action by Community Mental Health Center
- Action by Housing Authority of Cook County
- Action by Illinois Department on Aging

Abbreviations: Housing Spec.= Housing Specialist (HHCS/Featherfist/Access Living), CMHC = Community Mental Health Center, HACC = Housing Authority of Cook County, MCO = Managed Care Organization

Appendix – C Illinois Home and Community-Based Services Waivers for Colbert Class Members

WAIVER	ABBREVIATION	OPERATING AGENCY	TARGET POPULATION
Persons with Brain Injury	Brain Injury	DHS, Division of Rehabilitation Services	Persons with brain injury, all ages
Persons Diagnosed with HIV/AIDS	HIV/AIDS	DHS, Division of Rehabilitation Services	Persons with HIV/AIDS, all ages
Persons with Disabilities	Disability	DHS, Division of Rehabilitation Services	Persons with disabilities, ages 0-59 (will cover disabled persons over 60 if they entered program prior to 60th birthday)
Elderly	Elderly	IDoA	Persons over 60
Supportive Living Program	SLF	HFS, Division of Medical Programs	Frail elderly age 65 and older, or those age 22 to 64 with disabilities, living in a 24-hour assisted living facility

Appendix – C Illinois Home and Community-Based Services Waivers for Colbert Class Members

BASE SERVICE	BRAIN INJURY	HIV/AIDS	DISABILITY	ELDERLY	SLF
24 hour response/security staff					X
Adult day care	X	X	X	X	
Ancillary (transportation to group/community activities, shopping, arranging outside services)					X
Behavioral/cognitive services	X				
Day habilitation	X				
Environmental modifications	X	X	X		
Health promotion and exercise programming					X
Home delivered meals	X	X	X		
Home health aide	X	X	X		
Homemaker	X	X	X	X	
Housekeeping maintenance					X
Laundry					X
Medication oversight and assistance with self administration					X
Nursing	X	X	X		X

Appendix – C Illinois Home and Community-Based Services Waivers for Colbert Class Members

BASE SERVICE	BRAIN INJURY	HIV/AIDS	DISABILITY	ELDERLY	SLF
Occupational therapy	X	X	X		
Personal care	X	X	X		X
Personal emergency response system	X	X	X	X	X
Physical therapy	X	X	X		
Prevocational services	X				
Respite care	X	X	X		
Social/recreational programming					X
Specialized medical equipment and supplies	X	X	X		
Speech therapy	X				
Supported employment	X				

Appendix D - Training

A. Outreach Contractor Training

It is expected that the Outreach contractor will have procedures in place to train and supervise their staff. These procedures are to include a plan for on-going training of Transition Engagement Specialists; this plan is to be submitted to IDoA for review annually for the duration of the contractual arrangement. Minimally, topics to be included are:

- Background of the Colbert Consent Decree
- *MONEY FOLLOWS THE PERSON/COLBERT CONSENT DECREE*
- Social Work Methods of Person-Centered Practice, Strengths Perspective, Person in Environment
- Long Term Services and Supports and Waiver Options
- Older American Act Programs
- Rule 132 Mental Health
- Motivational Interviewing
- Multicultural Competence
- Engagement of a Class Member Regarding Community Transition
- Building Positive Relations with Nursing Facilities

A.1. Housing Specialist and Transition Staff Training

It is expected that HSAs will have procedures in place to train and supervise their staff. These procedures are to include a plan for on-going training of Housing Locators that will be reviewed in accordance with protocols developed by the Rebalancing Training Institute (see section XI). At a minimum, topics to be included are:

- Background of the Colbert Consent Decree
- Motivational Interviewing
- Multicultural Competence
- Engagement of a Class Member Regarding Community Transition
- Building Positive Relations with Nursing Facilities
- The Housing Search; Landlord Engagement
- Colbert Bridge Subsidy
- HQS Inspection Requirements
- Eviction Prevention
- Fair Housing
- Supportive Housing

Additional training will be offered as needed on topics including Colbert Consent Decree Implementation operational protocols, relevant statutes and best practices in community reintegration.

B. Managed Care Organization Staff Training

It is expected that the MCOs will have procedures in place to train and supervise their respective staffs. These procedures are to include a plan for on-going training of its staff that is

to be submitted to IDoA for review at least annually for the duration of the contractual agreement.

Annual training topics will include at a minimum the following:

- Background of the Colbert Consent Decree
- The Holistic Approach to Care Coordination using a Multi-Disciplinary Integrative Approach
- Building Positive Relations with Nursing Facilities
- Engagement of a Class Member Regarding Community Transition
- Multicultural Competence
- Philosophical Approaches to Meeting the Needs of People with Disabilities
- Social Work Methods of Person Centered Practice, Strengths Perspective, Person in Environment
- Health and Disease Management
- Physical and Behavioral Health Management and Treatment Options
- Motivational Interviewing
- Substance Abuse Management and Treatment Options
- Nutrition
- Caregiver Supports
- Expectations of Evaluation
- MFP Forms
- Financial Assistance and Insurance Programs
- Medical Assistance Benefits
- Long Term Services and Supports; Waiver Options
- Rule 132 Mental Health
- Older American Act Programs
- Legal Issues: Power of Attorney and Guardianship
- Natural Supports
- Housing Resources
- Professional Ethics
- Person-centered Care Planning

C. Training and Educating Housing Developers

IHDA, the Division of Mental Health (DMH), and the Corporation for Supportive Housing continue to provide supportive housing training for IHDA-funded developers. The goal of the trainings is to encourage housing developers to consider inclusion of PSH units in affordable housing developments.